PARTIAL HOSPITAL CARE

Definition

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines*) define Partial Hospital Care as "a level of care that is distinguished from 24-hour inpatient or intermediate/residential care only in that the person does not remain in the hospital 24-hours per day. Support and supervision must be sufficient to maintain the person's safety outside the hospital. Services of a high level of intensity are provided on-site."

Services are available a minimum of 4 hours per day and 5 days per week in an appropriately licensed facility. Treatment is intensive and is provided in a supervised environment by a multi-disciplinary team of qualified professionals including, but not limited to, Board-eligible or certified psychiatrists, clinicians, registered nurses, licensed mental health professionals, and other ancillary staff. Treatment is focused on the following:

- Reducing the risk of behaviors destructive to self or to others, including impulsive behaviors such as mutilation
- Reducing clinically significant disability
- Reducing the probability of impulsive behaviors which can be predicated to have a clinically significant risk based on the patient's history and current clinical presentation.
- Reducing the probability of behaviors likely to lead to the need for a higher level of care
- Reducing medical factors that are associated with a mental disorder and place the patient at significant risk

Prior Authorization Reviews

All admissions of Medicaid recipients to Partial Hospital Care require prior authorization and must meet medical necessity as defined in the *Clinical Management Guidelines*. (Refer to page PHC-15 of this section for the *Clinical Management Guidelines* specific to Partial Hospital Care.)

Continued Stay Reviews

All Partial Hospital Care serves that extend beyond the initial authorization date must be authorized through a Continued Stay Review. Discussion of the Continued Stay Review process beings on page PHC-6 of this section.

Retrospective Reviews

Partial Hospital Care services are not subject to Retrospective Review by First Health Services of Montana unless otherwise requested by the Department of Public Health and Human Services.

Discharge Procedure

Upon recipient discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a *Discharge Notification Form*. (See FORMS section of this manual.) This form must be submitted to First Health of Montana within five (5) business days after discharge.

PRIOR AUTHORIZATION REVIEW PROCEDURE

Definition

A partial hospital care admission is a scheduled admission that is subject to the choice or discretion of the recipient or the physician advisor regarding medical services and/or procedures that are medically necessary and advantageous to the client, but not necessary to prevent death or disability. Prior authorization is required for all admissions to a partial hospital care program.

Prior Authorization Review Procedure

1. The provider must verify the recipient's Medicaid eligibility.

2. The provider should notify First Health as soon as the need for admission is determined, but **must** notify First Health no later than 48 hours/two (2) business days prior to admission. This allows for timely completion of the pre-admission review process. This is a fax based notification process for submission of the request for prior authorization and pertinent information. (See FORMS section of this manual for the *Prior Authorization Request Form*.)

3. The provider must submit a completed and valid CON (see FORMS section) at least 48 hours/two (2) business days prior to admission. (Refer to page PHC-8 of this section for additional information regarding the CON).

NOTE: Reviews will not be completed until a valid CON is received.

4. The provider must submit a *Prior Authorization Request* form by fax that includes demographic and clinical information. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:

    - Demographic information
        - Recipient's Medicaid ID number (MID)
        - Recipient's Social Security Number (SSN)
        - Recipient's name, date of birth, and sex
        - Recipient's address, county of eligibility, telephone number
        - Responsible party name, address, phone number
        - Hospital name, provider number, and planned date of admission
    - Clinical Information
        - Prior inpatient treatment
        - Prior outpatient treatment/alternative treatment

- Anticipated date of admission
- Initial treatment plan
- DSM IV diagnosis on Axis I through V
- Medication history
- Current symptoms requiring partial hospital care
- Chronic behavior/symptoms
- Appropriate medical, social, and family histories
- Proposed discharge plan
- Completed CON as required in ARM 37.86.2801(1)(b). (See discussion regarding CON procedures for specific requirements, pages PHC 8-9 of this manual).

5. The recipient's treatment must be documented to meet all of the following criteria as stated in ARM 37.86.2801(1)(b):

    1) The recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairments in educational, social, vocational, and/or interpersonal functioning [37.86.2801(1)(b)(i)].

    2) The recipient cannot be safely and appropriately treated or contained in a less restrictive level of care {37.86.2801(1)(b)(ii)].

    3) Proper treatment of the beneficiary's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician [37.86.2801(1)(b)(iii)].

    4) The recipient can be safely and effectively managed in a partial hospitalization setting without significant risk of harm to self or others [37.86.2801 (1)(b)(iv)].

    5) The services can reasonably be expected to improve the recipient's condition or prevent further regression [37.86.2801(1)(b)(v)].

    6) The recipient has exhausted or cannot be safely and effectively treated by less restrictive alternative services, including day treatment services or a combination of day treatment and other services [37.86.2801 (1)(b)(vi)].

CONTINUED STAY REVIEW PROCEDURE

Definition

A continued stay review is a review of currently delivered treatment to determine ongoing medical necessity for a continued level of care.

Reviews of request for continued stay authorization are based on updated treatment plans, progress notes and recommendation of the individual's treatment team. Continued stay requests require prior authorization and must meet the medical necessity criteria as defined in the *Clinical Management Guidelines*. (Refer to page PHC-15 of this section for the Partial Hospital Care *Clinical Management Guidelines*.)

Continued Stay Review Procedure

1. The provider is responsible for contacting First Health Services of Montana by fax five (5) days prior to the termination of the initial certification.

2. The provider must submit a continued stay review request form by fax that provides sufficient information for the clinical reviewer to make a determination regarding medical necessity and must include:

    - Changes to current DSM-IV diagnosis on Axis I through V
    - Justification for continued services at this level of care
    - Assessment of treatment progress related to admitting symptoms and identified treatment goals
    - Current list of medications or rationale for medication changes, if applicable
    - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan

3. Upon fax receipt of the above documentation, First Health's clinical reviewer will complete the review process as demonstrated in the *Prior Authorization for Youth Residential Treatment Flow Chart* (Appendix A).

    - The authorization review will be completed within two (2) business days from receipt of the original review request and clinical information, providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.

- If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) day of the request for additional information, and
- The authorization review will be completed within two (2) business days from receipt of additional information.

4. If medical necessity is met **and** the CON has been completed at least 48 hours/two (2) business days prior to admission, the First Health reviewer will authorize the admission and generate notification to all appropriate parties.

5. If medical necessity is not met, then the case is deferred to a board-certified psychiatrist in the First Health National Clinical Review Center for review and determination.

CERTIFICATE OF NEED

Definition

A Certificate of Need (CON) is a state and Federal [ARM 37.86.2801(1)(b), CFR 441.152 and 441.153] requirement for documentation of medical necessity of partial hospitalization for Medicaid recipients. An interdisciplinary team or health care professionals develops the patient's plan of care and completes the CON. The CON certifies that:

1) The recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairments in educational, social, vocational, and/or interpersonal functioning [37.86.2801(1)(b)(i)].

2) The recipient cannot be safely and appropriately treated or contained in a less restrictive level of care {37.86.2801(1)(b)(ii)].

3) Proper treatment of the beneficiary's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician [37.86.2801(1)(b)(iii)].

4) The recipient can be safely and effectively managed in a partial hospitalization setting without significant risk of harm to self or others [37.86.2801 (1)(b)(iv)].

5) The services can reasonably be expected to improve the recipient's condition or prevent further regression [37.86.2801(1)(b)(v)].

6) The recipient has exhausted or cannot be safely and effectively treated by less restrictive alternative services, including day treatment services or a combination of day treatment and other services [37.86.2801 (1)(b)(vi)].

NOTE: Reviews will not be completed until a valid CON is received.

Partial Hospital Care Admission CON Procedure

When a recipient has been determined Medicaid eligible by the department as of the time of admission to the partial hospitalization program, the CON must:

- Be completed, signed and dated prior to, but no more than 30 days before admission; and [ARM 37.86.2801(1)(c)(i)]

- Made by a team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry, a licensed mental health professional and an intensive case manger employed by a mental health center. [ARM 37.86.2801(1)(c)(ii)]

- No more than one member of the team of health care professionals may be professionally or financially associated with the partial hospitalization program.

- For individuals who are transferred from a hospital's acute inpatient program to the same facility's partial hospitalization program, the certificate of need may be completed by a facility-based team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the individual's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in psychiatry, and a licensed mental health professional. The certificate of need must also be signed by an intensive case manager employed by a mental health center.

The independent team will complete the CON and submit it with the request for prior authorization. (Submission should occur as soon as the need for admission is determined, but **must** occur at least 48 hours/two (2) business days prior to admission.) The provider must maintain the original CON and provide a copy to First Health Services of Montana.

If an individual is transferred from acute inpatient to a partial hospitalization program within the same facility, the acute inpatient CON (for individuals under 21 years of age) or facility based CON will be accepted, with the addition of a signature by the intensive case manager.

During the prior authorization review, First Health Services of Montana will ensure that the physician signing the CON is eligible to do so per federal and state CON requirements. First Health Services of Montana will verify that that CON was received an complete before entry into the database. Prior authorization is dependent upon not only meeting medical necessity, but also completion of the CON at least 48 hours/two (2) business days prior to admission.

DETERMINATIONS

Upon completion of the review, one of the following determinations will be applied and notification will be made as outlined in **Notification Process** of this section:

1) **Authorization**:

An authorization determination indicates that utilization review resulted in approval of all provider requested services and /or service units and a prior authorization number is issued.

2) **Pending Authorization**:

Indicates that a First Health Services of Montana reviewer or First Health psychiatrist has requested additional information from the provider. The provider will have five (5) days to provide any additional information needed to make a payment determination.

3) **Partial Approval**:

Partial approval is considered an adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested. Only a First Health psychiatrist may issue a partial approval. Partial approvals are subject to the First Health Services of Montana Appeal process.

4) **Denial**:

The request for authorization of payment does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payment for the services requested. Authorization for payment is denied. Only a First Health psychiatrist may issue a denial. Denials are subject to the First Health Services of Montana Appeal process.

5) Technical Denial (Administrative Denial):

A prior authorization review was not administered on medical necessity criteria as a result of provider Medicaid protocol non-compliance. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete. Technical denials may be appealed to the Children's Mental Health Bureau within 30 days of date of notification.

> ***NOTE:*** The ARM specifically states, "An authorization by the department of its utilization review under this rule is not final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time."

NOTIFICATION PROCESS

First Health Services of Montana recognizes the importance of prompt notification to all relevant parties with regard to authorizations and denials. "Relevant parties" is defined as beneficiaries, families or guardians of beneficiaries, requesting providers, and the Department. When appropriate, First Health Services of Montana will notify the Regional Care Coordinator to assist in the transition to other levels of care.

First health Services of Montana will implement a two-step notification process, providing both informal and formal notification.

Informal Notification

Informal notification will be completed via facsimile on a daily basis and will include an:

- **Outcome report to the department of all determinations, regardless of region or provider**
- Outcome report of all determinations will be given to each provider (provider specific information only)
- Outcome report of all determinations will be provided to the Regional Care Coordinator (region specific only).

The above outcome reports are generated and transmitted via facsimile by 9:00 AM Mountain Time on the next business day.

Formal Notification

Formal notification will be made providing all relevant parties with a hardcopy determination sent by US Mail.

- Authorization determinations will be mailed by regular US mail
- Denial determinations (technical denial or denial for medically unnecessary) will be mailed certified, return receipt mail and tracked to ensure delivery.
- Notifications for technical denials will include:
- Dates of service that are denied a payment recommendation because of non-compliance with Administrative Rule
- Reference applicable to federal and/or state regulations

- An explanation of the right of the parties to request an Appeal
- Name and address of person to contact to request an Appeal
- A brief statement of the First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews
- Notifications for denial determinations for medically unnecessarily treatment/services will include:
- Dates of service that are denied a payment recommendation because the services in question are considered medically unnecessary according to Medicaid criteria or protocols
- Case specific denial rationale based on the medical necessity criteria upon which the determination was made
- Reference federal and/or state regulations governing the review process
- Date of notice of First Health Services of Montana's decision which is the date of printing and mailing; and/or the date of the confirmed facsimile transmission
- An explanation of the right of the recipient (or legal guardian), the psychiatrist/physician, and/or the provider to request an Appeal
- Name and address of person of office to contract to request an Appeal
- A brief statement of First Health Services of Montana's contractual responsibility to the State of Montana for utilization reviews

FIRST HEALTH SERVICES OF MONTANA
APPEAL PROCESS

Definition

Appeal—Consumer, provider, or agent's challenge of a denial. Appeal may be indicated through the use of any one of the following terms: Appeal, Administrative Review, Reconsideration, or Fair Hearing.

Process

All adverse determinations are made by Board-certified psychiatrists. The First Health Services of Montana review process is designed to take advantage of the Montana-specific knowledge of treatment availability, access, and program strengths that the Montana physician panel brings to the determination process. Therefore, First Health Services of Montana will defer appeals to a Montana-based physician for final determination whenever possible. First Health's panel includes a sufficient number of psychiatrists certified by the American Board of Psychiatry and Neurology so that all appeal determinations will be completed by a psychiatrist not involved in the original adverse determination. This process allows for a choice of a peer-to-0peer or a desk-based review using the following process:

a. Upon receipt of an adverse determination, the recipient or recipient's guardian or the provider/facility may request an appeal of the adverse determination.

b. The request for appeal must be received at the First Health Services of Montana, Helena office within 30 day of the date of receipt of the determination notice.

c. The request for appeal must specify the option of peer discussion/review or desk review. Any additional information to be considered must be included with the request.

Peer-to-Peer Discussion/Review:
Scheduling of peer reviews must be requested and coordinated through the First Health Services of Montana, Helena office. To permit completion of the appeal process within five (5) business days of receipt of the request, the peer-to-peer discussion will be requested and must be completed within 72 hours/three (3) business days of receipt of the request.

Desk Review:

A desk review will be performed whenever a peer review has not been requested or when the request for appeal does not specify peer discussion or desk review.

d. First Health Services of Montana completes the appeal review within five (5) business days of the receipt of the request. A Board-certified psychiatrist, who has no prior knowledge of the case of professional relationship or ties with the provider, completes the reconsideration review. Whenever possible, Montana licensed and based Board-certified psychiatrists will complete these reviews.
e. All final determinations include rational for the determination based upon the applicable federal and state regulations, and include instructions as to the rights of further appeal.
f. The determination rendered by the appellate physician performing the review will, in all cases, stand as the final First Health Services of Montana decision.
g. If the appeal review upholds by the adverse determination, the rights of the provider and/or beneficiary to an administrative review or reconsideration with the Montana Department of Public Health and Human Services will be included in the formal notification. First Health Board-certified psychiatrists may provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

Please refer to Appendix C for the *First Health Services of Montana Appeal Process* Flow Chart.

Notification Process—Appeal Determinations

In accordance with state and federal policy, First Health Services of Montana will provider written notification of the appeal determination to the recipient or recipient's legal guardian and the provider/facility of their right to the next level of appeal. Notification will include those elements as discussed in the **"Notification Process"** of this section.

Fair Hearing Process

First Health will be available to participate in the Medicaid Fair Hearing process to provide testimony related to the determination under appeal and will provide copies of all documentation and correspondence related to the determination under appeal.

Please refer to the notification letter for detailed instructions regarding Appeals/Reconsiderations/Administrative Review/Fair Hearing processes.

PARTIAL HOSPITAL CARE
CLINICAL MANAGEMENT GUIDELINES

First Health Services of Montana will employ the use of the *Montana Medicaid Clinical Management Guidelines* strictly as guidelines. This practical application, coupled with professional judgement based on clinical expertise and national best practices, will enhance the rendering of authorization decisions for both the adult and under 21 years of age populations.

The *Clinical Management Guidelines* for Partial Hospital Care, including service components, admission, continued stay, and discharge criteria are as follows:

Services Components (must meet all of the following)

1. Minimum of four (4) hours of active mental disorder treatment per day within a structured therapeutic milieu (exclusive of formal education and support groups administered by non-licensed/certified personnel) which includes individual and/or group therapy.

2. Person must be seen and evaluated by a physician who will participate with the multi-disciplinary team in preparation of an individualized, documented treatment plan directed toward the alleviation of the impairment(s) that caused the admission.

3. Involvement of family and all active pre-admission caregivers, in evaluation, treatment planning activities, and in treatment as appropriate.

4. Active discharge planning must be initiated at time of admission to program and culminates in comprehensive discharge plan.

5. Active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

6. Treatment plan is regularly updated to reflect person's progress and/or new information that has come available.

7. Regular assessment and active interventions are completed by nurses, therapists, and physicians based upon the comprehensive treatment plan.

Admission Criteria (must meet all of the following)

1. A covered DSM-IV diagnosis as the principal diagnosis

2. The recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairment in educational, social, vocational, and/or interpersonal functioning.

3. The recipient cannot be safely an appropriately treated or contained in a less restrictive level of care.

4. Proper treatment of the recipient's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician.

5. The recipient can be safely and effectively managed in a partial hospital setting without significant risk of harm to self/others.

6. The services can reasonably be expected to improve the recipient's condition or prevent further regression.

7. Discharge planning will be initiated at the time of admission.

Continued Treatment Criteria (must meet 1 and 2 and 3, and either 4 or 5 or 6):

1. A covered DSM-IV diagnosis as the principal diagnosis

AND

2. Active treatment is occurring which is focused on stabilizing or reversing symptoms which meet the admission criteria and which still exists.

AND

3. A lower level of care is inadequate to meet the patient's needs with regard to either treatment or safety.

TOGETHER WITH

4. There is a reasonable likelihood or clinically significant benefit, including stabilization, and reduced probability of future need for a higher level of care, as a result of medical intervention requiring the partial hospital setting.

OR

5. A high likelihood of either risk to the patient's safety or clinical well being or of further significant acute deterioration in the patient's condition without continued care in the partial hospital setting, with lower levels of care inadequate to meet these needs.

OR

6. The appearance of new impairments meeting the admission guidelines.

Discharge Criteria (must meet 1 and 2 or 3)

1. The symptoms/behaviors that required services at this level of care have improved sufficiently to permit treatment at a lower level of care.

AND

2. A comprehensive discharge plan has been developed and is ready to be implemented.

OR

3. The patient voluntarily withdraws from treatment or the person's parent or legal guardian removed them from the program.